MDR Tracking Number: M5-04-3640-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-28-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, group therapeutic procedures, ROM measurements, manual therapy, special reports, muscle testing, mechanical traction and massage therapy from 1-7-04 through 4-14-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 1-7-04 through 4-14-04 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of August 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 8/23/04

TWCC Case Number:
MDR Tracking Number: M5-04-3640-01

Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

August 17, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a neck and shoulder injury while at work on ___. The patient appears to have presented initially to Dr. H, DO, and was diagnosed with chondritis and trapezious strain. The patient was treated conservatively with medications, ice and rest. Imaging studies from 01/27/03 and 01/29/03 suggest flattening of the cervical lordosis and degenerative disc disease with small central disc protrusion at C4 and C6. The patient appears to be followed by a Dr. W, DO, and a Dr. R on or before 02/13/03, still treating conservatively for cervical, thoracic

and shoulder sprain/strain. The patient also appears to see a Dr. R, DC, for chiropractic treatment and physical therapy. An EMG study is performed 02/28/03-suggesting evidence of median nerve entrapment but negative for cervical radiculopathy. The patient appears to undergo a work hardening program with Dr. R, but little documentation for this is provided for review. The patient is referred to a Dr. L, DO, on 06/05/03 and is found with anterior shoulder impingement and cervical disc syndrome. Epidural steroid injections are recommended. The patient appears to return to Mexico (her native home) for several months and discontinues treatment. On 11/18/03, the patient appears to present to another chiropractor, Dr. K, DC, where she is continued with physical therapy and has a repeat MRI performed. Radiology report from 12/02/04 suggests subacromial fibrosis, hypertrophy and some possible subacromion bursitis. No chiropractic notes are provided prior to 01/07/04. Chiropractic notes submitted from 01/07/04 to 04/14/04 suggests that conditions are largely unchanged with extensive physical therapy and diagnostic testing. A designated doctor evaluation is made 02/12/04. At this time, the patient denies any particular shoulder pain. Another medical exam is performed 03/24/04 by a Dr. F, MD, suggesting that MMI has been achieved and no additional treatment to her right shoulder is necessary.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99212, 99211), therapeutic exercise (97110), group therapeutic procedures (97150), ROM measurements (95851), manual therapy (97140), special reports (99080), muscle testing (95831), mechanical traction (97012) and massage therapy (97124) for period in dispute from 01/07/04 through 04/14/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for these ongoing treatments and services (01/07/04 through 04/14/04) **are not supported** by available documentation. Ongoing testing and therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms at 1+ year post injury. In addition, extensive testing and therapy has been performed prior to 01/07/04 services, and all services provided beyond this date would appear largely duplicative.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
3. Harris GR, Susman JL: "*Managing musculoskeletal complaints with rehabilitation therapy*" Journal of Family Practice, Dec, 2002.
4. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.